

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

418-63-004068
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED JAN 22 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jefferson	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		Length of stay in 1b 1 Mo-21 days	
c. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis-Little Rock Hospital, Inc.		d. STREET ADDRESS 616 S. 4th St	
3. NAME OF DECEASED (Type or print) First Joseph Middle Clarence C. Last Sansoucie		4. DATE OF DEATH Month January Day 14 Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-29-1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pen. Section Laborer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. FATHER'S NAME John Sansoucie		13b. MOTHER'S MAIDEN NAME Margaret Govero	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates) NO		17. INFORMANT Clarence Sansoucie, DeSoto, Mo.	
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Lymphatic Leukemia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 204.0 DUE TO (c) 204.0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Benign Prostatic Hypertrophy PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH More than a year
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 7:25 a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION DeSoto, Mo.	
21. I attended the deceased from December 24, 1962 to January 14, 1963		21. I attended the deceased from January 13, 1963 to January 13, 1963	
22a. SIGNATURE Clarence C. Sansoucie MD		22b. ADDRESS 1755 S. Grand Blvd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1/16/63	
23c. NAME OF CEMETERY OR CREMATORY Calvary		23d. LOCATION (City, town, or county) DeSoto, Mo.	
24. FUNERAL DIRECTOR Mothershead Funeral Home, DeSoto, Mo.		25. DATE RECD. BY LOCAL REG. JAN 15 1963	
26. REGISTRAR'S SIGNATURE Paul Smith, M.D.		26. REGISTRAR'S SIGNATURE	

USE BLACK INK
OR
TYPEWRITER RIBBON

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Andrew England

Licensed Embalmer No.

4745

P. O. Address

De Soto, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.